STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. BUILDING 00 B. WING	12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN HOME & REHABILITATIVE CENTER	231 N JACKSON ST OAKLAND CITY, IN 47660

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: November 04, 05, 06, 07, 10, 11, 12, 13, 2012 Facility number: 000327 Provider number: 155561 AIM number: 100273920 Survey team: Amy Wininger, RN TC Diane Hancock, RN (November 4, 5, 6, 7, 10, 11, 12, 2012) Vickie Ellis, RN Barb Fowler, RN (November 4, 5, 6, 7, 11, 12, 13, 2012) Census bed type: SNF/NF: 86 Total: 86 Census payor type: Medicare: 13 Medicaid: 50 Other: 23 Total: 86 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 12/17/12 by Suzanne	F0000	The creation and submission of this plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or of any violation or regulation. The provider respectfully request that the 2567 plan of correction be considered the letter of credible allegation and request a post certification desk review in lieu of a post survey re-visit on or after January 4, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Williams, RN			

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F0272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.			
	Based on observation, interview and record review, the facility failed to ensure the comprehensive assessments were accurately completed for 2 of 3 residents	F0272	1. Resident #60 and resident #104 have suffered no ill effects from the alleged deficient practice. A correction will be submitted on resident #60 and resident #104 MDS by 1-4-2013	01/04/2013

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	reviewed for dental issues, of 7 who met the criteria for dental issues. (Residents #60, #104) Findings include: 1. Resident #60 indicated, during an interview on 12/4/12 at 3:42 p.m., he had no teeth and his dentures were at his brother's house. The resident was observed, at that time, to have no teeth. Resident #60's clinical record was reviewed on 12/7/12 at 10:28 a.m. The resident was admitted to the facility on 10/30/12. The resident's initial Minimum Data Set [MDS] assessment, dated 11/5/12, indicated there were no dental issues, i.e. "None of the above were present." One of the choices for the assessment was "edentulous." 2. On 12/5/12 at 9:52 a.m. an interview was done with Resident #104. During that time an observation was made of Resident #104. The resident had several		to reflect the correct answer to the dental questions regarding missing or broken teeth.2. All residents who reside in this facility have the potential to be effected by the alleged deficient practice. A complete audit of MDS admission assessments for the last 3 months will be completed by 1-4-2013 to ensure coding on the MDS is accurate regarding dental issues. Any mistakes found will be corrected and re-submitted.3. All new admissions will be audited by DNS/designee for 6 months. MDS assessment nurse and nurse managers will be in-serviced by DNS Specialist by 1-4-2013 on properly coding the dental section on the MDS to reflect dental issues present upon admission.4. To ensure compliance, the DNS/designee is responsible for the completion of the MDS assessment CQI tool on every new admission for 6 months to ensure continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. If the 95% threshold is not achieved an action plan will be developed to ensure compliance.	

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	broken teeth on the bottom and no teeth on the top. The resident indicated he did have dentures for the top, but they were broke. In an interview with the Executive Director on 12/9/12 at 1:00 p.m., she indicated Resident #104's dentures were broken prior to being admitted to the facility. The clinical record review done on 12/09/12 at 11:00 a.m. showed no indication of missing or broken teeth on the admission Minimum Data Set assessment [MDS] dated 9/18/12. 3.1-31(c)(9)			

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F0329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, interview, and record review, the facility failed to ensure medications administered for pain were monitored for effectiveness for 1 of 10 residents reviewed for unnecessary medications. (Resident #82) Findings include: The clinical record of Resident #82 was reviewed on 12/07/12 at 10:32 a.m. The record indicated the	F0329	1. Resident #82 suffered no ill effects from the alleged deficient practice. Resident #82 was assessed per physician on 12-18-2012 and it was determined that resident #82 had a need for routine pain medication. Routine pain medication was ordered and is now being administered.2. All residents who reside in this facility have the potential to be effected by the alleged deficient practice. An audit of all PRN pain medication documentation will be done by DNS/designee by	01/04/2013

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	diagnoses included, but were not limited to, neuropathy and dementia with behavioral disturbance. Resident #82 was observed on 12/4/12 at 12:00 p.m. sitting in a wheelchair in the dining room. During an interview, at that time, Resident #82 indicated sometimes he had shoulder pain. The most recent quarterly MDS [Minimum Data Set Assessment], dated 09/04/12, indicated Resident #82 had moderately impaired cognition. The December 2012 Physician's Order Recap included, but was not limited to, an order dated 05/25/12 for "Norco [Lortab] [a narcotic pain medication] 5/325 mg (10-650mg) po [by mouth] every 4 hours prn [as needed] pain/temp [temperature]." A Pain Assessment dated 12/03/12, indicated Resident #82 was interviewable and had experienced pain in the back and shoulder frequently over the previous five days, which had limited day to day activities. The December 2012 MAR [Medication Administration Record]		1-4-2013 to ensure the proper follow-up and effectiveness of PRN pain medication is being assessed.3. All licensed nurses will be in-serviced by DNS by 1-4-2013 on the policy for documenting PRN medication and proper follow-up pain assessments. Unit managers will review MAR daily every shift on residents with PRN pain medication orders to ensure proper pain follow-up assessments are being done and the effectiveness of the medication is known.4. To ensure compliance, the DNS/designee is responsible for the completion of the pain assessment follow-up CQI tool by auditing the MAR for residents on PRN pain medication for proper follow-up assessments to ensure the effectiveness of administered pain medication weekly times 4 weeks, bi-monthly times 2 months and then quarterly until continued compiance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. If the threshold of 100% is not achieved an action plan will be developed to ensure compliance.	

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	indicated Resident #82 received Lortab prn on 12/02/12, 12/03/12, and 12/05/12. A nurse's medication note dated 12/02/12 at 9:45 a.m. indicated Resident #82 had received Lortab for shoulder pain, which the resident had rated an "8" on a scale of 1 to 10. The note lacked any documentation of follow up monitoring. A nurse's medication note dated 12/03/12 at 4:00 p.m., indicated Resident #82 had received Lortab for back pain. The note lacked any documentation of follow up monitoring. A nurse's medication note dated 12/05/12 at 6:40 p.m., indicated Resident #82 had received Lortab for back pain, rated 8/10. The note lacked any documentation of follow up monitoring. A care plan, dated 09/12/12, for potential for pain, had interventions that included, but were not limited to, "...document effectiveness of prn medications..." During an interview with the DoN [Director of Nursing] on 12/12/12 at 8:40 a.m., she indicated the nursing			

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	staff should follow up on medication given prn to assess effectiveness. She further indicated at that time nurses usually used a pain scale to assess effectiveness. A policy and procedure for Pain Management, provided by the DoN on 12/12/12 at 10:00 a.m., indicated, "...7. Additional information including, but not limited to, ...effectiveness of pain medication will be documented on the back of the Medication Administration...." 3.1-48(a)(3)			

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F0431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medications with the potential for abuse were stored under a double	F0431	1. Resident #58 and resident #150 suffered no ill effects from the alleged deficient practice. Resident #58 and resident #104 schedule IV narcotics are now	01/04/2013

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	lock system, in that, Ativan in injectable liquid form [a schedule IV medication for anxiety], belonging to 2 residents, was observed to be stored in two of four medication rooms in unlocked refrigerators. [Resident #58, #150]. Findings include: During a medication storage observation on 12/10/12 at 3:35 p.m., the medication refrigerator in the medication room on the station 3 unit stored a vial of 2 mg Ativan with Resident #58's name on it. The medication was stored in a locked medication room, but it was not stored under a second lock. During an interview, at that time, RN #2 indicated controlled substances should be under double lock. During a medication storage observation on 12/10/12 at 3:40 p.m., the medication refrigerator in the medication room on the moving forward unit stored 30 vials of 2 mg Ativan with Resident #150's name on it. The medication was stored in a locked medication room, but it was not stored under a second lock. During an interview with the Executive Director on 12/11/12 at 9:30 a.m., she		stored under a double-lock.2. All residents who reside in this facility have the potential to be effected by the alleged deficient practic. Lock boxes were placed in all medication room refrigerators on 12-11-2012. 3. All licensed nurses will be in-serviced by DNS by 1-4-2013 on the policy for the storage on schedule IV narcotics. Licensed nurses on each unit will check at the beginning and end of every shift to ensure schedule IV narcotics in the medication room refrigerators are under a double-lock.4. To ensure compliance, the DNS/designee is responsible for the completion of the schedule IV narcotic storage policy CQI tool by auditing refrigerated schedule IV narcotics in every unit medication room weekly times 4 weeks bi-monthly times 2 months and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the QA committee overseen by the ED. If the 95% threshold is not achieved an action plan will be developed to ensure compliance.	

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	indicated she had reviewed their policy on the storage of medications, and it indicated scheduled medications needed to be stored with two locks. On 12/11/12 at 9:35 a.m. the Executive Director provided a policy and procedure for medication storage, dated revised 7/2011. The policy indicated Schedule IV must be kept in a separately locked drawer or cabinet designed for that purpose. 3.1-25(n)			

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F0441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review, the facility failed to	F0441	1. Resident #13 suffered no ill effects from the alleged deficient	01/04/2013

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	provide proper handwashing and glove use for 1 of 5 residents observed who received personal care. (Resident #13) Findings include: Resident #13 was observed to be receiving a bed bath on 12/7/12 at 9:45 a.m. by CNA # 1. CNA #1 had gloves on before giving the resident care. CNA #1 uncovered the resident and removed her gown. At 9:47 a.m., CNA # 2 entered Resident #13's room to assist CNA #1 with the resident's bath. CNA #2 did not wash his hands or apply gloves. CNA #2 covered the resident with her sheet and assisted with turning and repositioning the resident during the bath. While giving pericare to the resident, CNA #1 washed, rinsed, and dried the resident's periarea from back to front. While bathing the resident's legs, CNA #1 indicated the resident had scratches on her right inner thigh area. CNA #2 indicated he would notify the nurse and left the resident's room without washing his hands. CNA #2 returned with RN #1 and RN #1 observed the scratches. RN #1 indicated the resident scratches her legs often and the resident has medication to apply to the area. CNA #2 and RN #1 did not wash their		practice. Resident #13 is now receiving personal care that follows proper infection control techniques.2. All residents that reside in this facility have the potential to be effected by the alleged deficient practice. CNA #1, CNA #2, and RN #1 were all immediately in-serviced on personal careinfection control techniques. Infection control skills validation on CNA #1, CNA #2, and RN #1 were completed on 12-11-2012.3. The nursing staff will be in-serviced by DNS on personal care infection control technique, hand-washing and gloving by 1-4-2013. Nursing staff will be checked off on infection control skills validation by DNS/designee by 1-4-2013. Licensed nurses will round their units and observe ADL care on their units to ensure proper personal care infection control techniques are being followed. 4. The ensure compliance, the DNS/designee is responsible for the infection control CQI tool by observing 50 episodes of personal care weekly times 4 weeks, bi-monthly times 2 months and quarterly until continued compliance is achieved for 2 consecutive quarters. The results of these observations/audits will be reviewed by the QA committee overseen by the ED. If the 95% threshold is not achieved an action plan will be developed.Infection control skills	

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	hands or apply gloves. RN #1 left the resident's room without washing her hands. CNA #1 continued to bathe the resident with the assist of positioning from CNA #2. At 9:54 a.m., CNA #2 indicated another resident's call light was on and left the resident's room without washing his hands. He returned at 9:56 a.m. and continued with turning and changing Resident #13's brief without washing his hands or applying gloves. CNA #1 completed the resident's bath and changed the resident's brief and applied a clean shirt without changing her gloves or washing her hands. CNA #1 and CNA #2 placed the resident's lower extremities on a pillow and CNA #1 applied a splint to the resident's left lower leg and foot. CNA #2 indicated he needed to find another TED hose [a type of anti-embolus stocking] for the resident and left the room without washing his hands. After completing the resident's care, CNA #1 removed her gloves, but did not wash her hands, and combed the resident's hair. The DoN [Director of Nursing] was informed of the bathing technique on 12/11/12 at 11:00 a.m. Interview with DoN on 12/12/12 at 8:30 a.m., indicated CNA #1 and CNA		validation will be c ompleted on all shifts daily for 1 week, bi-weekly for 1 week, and monthly for 6 months. Results of the skills validation will be reviewed by the QA committee overseen by the ED. If 95% compliance not achieved an action plan will be developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155561	A. BUILDING 00 B. WING	12/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	#2 were both inserviced and were being "checked off" on their skills today. The "Transmission-Based Precaution Guidelines" for handwashing and glove use, dated 05/2012 and obtained on 12/12/12 at 1:40 p.m. from the DoN, indicated handwashing is to be performed before having direct contact with a resident and gloves are to be worn when providing direct patient care and changed during care if hands move from a contaminated site to a clean site. 3.1-18(l)			